AMERICAN MARITIME OFFICERS (AMO) PLANS

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APPLICATION FOR BENEFITS

TO BE COMPLETED BY EMPLOYEE OR DEPENDENT SPOUSE

EMPLOYEE INFORMATION			
Participant's Name:		SSN:	DOB:
Street address:	City:	State:	ZIP Code:
Telephone number:	Marital status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Legally Separated		
Last or present employer:		Vessel:	
Dates of employment:		C.O.B.R.A: ☐Yes ☐No	
If retiree, effective date of Pension:	Type of Pension:		

PATIENT INFORMATION			
Patient name:		SSN:	DOB:
Street address:	City:	State:	ZIP Code:
Relationship to member: ☐Self ☐Spouse ☐Child ☐College Student ☐Other:			Patient's sex: ☐Male ☐Female
Is the patient employed: ☐Yes ☐No	If yes, ☐Full-time ☐Part-time	Name of employer:	
Address of employer:	City:	State:	ZIP Code:
Does patient have access to Group Coverage through employment, or any other source (i.e. Medicare?)			☐ Yes ☐No
If yes, name of policy holder:			
Name of carrier:		Effective date:	
Type of coverage: ☐ Group Insurance ☐ Individual Policy	Did participant reject coverage offered by the employer: ☐Yes ☐No		
If yes, date the coverage was rejected:	Date of next enrollment:		

CLAIM INFORMATION		
Was the condition related to an accident?	☐ Yes ☐ No	Is yes, please explain: (how/when/where)
Was the condition related to Patient's employment?	☐ Yes ☐ No	Is yes, please explain: (how/when/where)
Was the condition in any way motor vehicle related?	☐ Yes ☐ No	Is yes, please explain: (how/when/where)
Did the condition occur while aboard a vessel?	☐ Yes ☐ No	Is yes, please explain: (how/when/where)

ASSIGNMENT OF BENEFITS				
Assign Benefits (pay provider)		Date of Service (mm/dd/yyyy)	Doctor and/or Provider's Name	Amount
☐ Yes	☐ No			$
☐ Yes	☐ No			$
☐ Yes	☐ No			$
Note: we must receive and keep the original bills, receipts and claim forms for our records. We suggest you make copies for your records.				

SIGNATURE	
I hereby certify that the information contained herein is true. I understand that if I make a false statement and collect money fraudulently from the American Maritime Officers Medical Plan, I will be responsible for repayment and am liable to expulsion from the American Maritime Officers Union in accordance with the terms of the Union's Constitution and By Laws. I understand and agree that I am bound by the Subrogation provisions contained in the Rules and Regulations of the American Maritime Officers Medical Plan pursuant to which I am required to reimburse the Plan for any expenses paid in connection with an injury or illness for which I recover any amounts from a third party. I authorize the provider who rendered the service to furnish the American Maritime Officers Medical Plan with any evidence or information about my claim that it may request. I hereby authorize the American Maritime Officers Medical Plan to pay the provider directly, if any part in Assignment of Benefits is answered "Yes", I understand the payment to the physician and / or hospital represents a benefit which would be payable to me.	
Signature of Employee/ Dependent:	Date:

<u>HOSPITAL EXPENSES:</u> Room and Board and Hospital Ancillaries will be billed directly from the hospital to the American Maritime Officers Medical Plan. All hospital bills must be sent on form UB92. The UB92 is a standard hospital claim form and is accepted by American Maritime Officers Medical Plan. You do not need to complete an Application of Benefits.

<u>APPLICATION FOR BENEFITS:</u> In order for a medical expense to be considered for benefit reimbursement, the Employee or the Employee's Spouse must complete an Application for Benefits. In order for this form to be accepted, you must answer every question.

If a provider sends a bill directly to the American Maritime Officers Medical Plan without an Application for Benefits, the employee will receive a notice from the Plan advising that the benefit cannot be paid until an Application for Benefits is received. The Employee or his Dependent Spouse must complete the form.

If you go to the doctor or laboratory, bring along a completed Application for Benefits form, and tell the provider that the claim form must be attached to any claim for benefit payment.

- Separate itemized bills must be submitted together with a separate claim form for each patient.
- If American Maritime Officers Medical Plan is primary, you must attach original itemized bills for all expenses being claimed.
- If American Maritime Officers Medical Plan is not the primary, then you must submit legible copies of itemized bills for all expenses being claimed along with any payment or rejection notices (usually called "Summaries" or "Explanation of Benefits") from the primary insurer.

Cash register receipts, cancelled checks, money order receipts, statement of account and personal itemizations are <u>NOT ACCEPTABLE</u> as itemized bills.

Please be sure all bills being submitted contain the following:

- Name, professional title (e.g. M.D., D.O., D.D.S.,) Tax ID Number (TIN), and address on the official bill-head of the Provider rendering the service or supplying the item. The bill must be signed by the provider of service.
- Patient's full name.
- Type of service rendered (e.g. doctor's office visit, nurse's services, optical exam, ect.) or item supplied (e.g. prescription drugs, eyeglasses, corrective lenses, ect.)
- The date and amount charged for each service rendered or item supplied.

Bills for the following services must have the following additional information:

- **Doctor visits:** the Doctor's bill must state the diagnosis (ICD Code), type of procedure (CPT Code), date of treatment and amount charged for each service.
- **Prescription drugs:** the pharmacy bill must state the patient's name, the pharmacy's name, address, the prescription number (Rx number) and drug name. If the purchase is a refill, the refill date must be indicated on the bill.
- **Durable medical equipment supplies (wheelchairs, braces, oxygen, etc.):** the Physician's authorization for the specific item needed must be submitted. If renting, have the Physician note the length of time the item will be medically needed. All durable equipment should be pre-approved by the Plan to be sure the equipment meets the Plan's definition of medical necessity.
- **Therapeutic treatment:** a Physician's statement of the specific treatment. The statement must include diagnosis, prognosis, and length of treatment.
- **Dental care:** the Dentist must complete a dental claim form outlining tooth number or letter, surface, description of service, ADA code (the AMO Medical Plan provides a form, which you can bring to your dentist, or he can use a standard dental claim form.)
- **Eye care:** the bill must include the diagnosis.

<u>ASSIGNMENTS OF BENEFITS:</u> The American Maritime Officers Medical Plan will pay the Provider directly, provided the employee or his Dependent Spouse authorizes the Assignment of Benefits on the Application for Benefits form supplied by the Plan. The Plan will not accept the Provider's statement that your authorization is on file in their office.

<u>Additional Comments:</u> (if needed)

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